ARIZONA DEPARTMENT OF HEALTH SERVICES
Office of Special Licensing
Request For Waiver of Speech-Language Pathology Assistant Licensing Requirements

A.R.S. § 36-1940.04.B provides that the Director grant a waiver of the requirements for licensure as a speech-language pathology assistant until September 1, 2007 to individuals who have performed the functions of a speech-language pathology assistant if the individual:

1. Has completed a minimum of forty semester credit hours of speech-language pathology technical course work.
2. Has satisfactorily completed a minimum of two years of experience as speech-language pathology assistant under the supervision of a licensed master's level speech-language pathologist.
3. Is of good moral character.
4. Has not had a license revoked or suspended by a state within the past two years and is not presently ineligible for licensure in any state because of a prior revocation or suspension.

IDENTIFYING INFORMATION OF PERSON REQUESTING WAIVER:

Name: _____

Mailing Address: _____ State: _____ Zip: _____

Home Telephone Number: ( ) _____ Business Telephone Number: ( ) _____

PERSONAL AND PROFESSIONAL CONDUCT (If the answer to any of the following questions is Yes, explain fully in separate signed and dated affidavit)

Are you currently, or have you:	**Yes**	**No**
1. Been convicted or a felony or misdemeanor involving moral turpitude in this or any other State, Territory or Country?	*	*
2. Had a license revoked or suspended by a state within the past two years?	*	*
3. Presently ineligible for licensure in any state because of a prior revocation or suspension?	*	*

REQUIRED DOCUMENTATION (Please provide the following documentation with this request)

1. Official transcript(s) from a nationally or regionally accredited college or university demonstrating completion of a minimum of forty semester credit hours of speech-language technical course work.
2. Documentation of satisfactorily completing a minimum of two years of experience as a speech-language pathology assistant under the supervision of a licensed master's level speech–language pathologist. (Please use the form provided with this request document)

I CERTIFY THAT THE INFORMATION AND DOCUMENTATION PROVIDED ON OR WITH THIS REQUEST FOR WAIVER IS TRUTHFUL, COMPLETE AND ACCURATE.

_____ _____

Signature of Requester Date

THIS REQUEST, AND ALL REQUIRED DOCUMENTATION, MUST BE SUBMITTED TO THE ARIZONA DEPARTMENT OF HEALTH SERVICES, OFFICE OF SPECIAL LICENSING, 150 N. 18TH AVENUE, SUITE 460, PHOENIX ARIZONA 85007 PRIOR TO SEPTEMBER 1, 2007.

THE DEPARTMENT WILL NOTIFY INDIVIDUALS OF ITS DETERMINATION FOR GRANTING A WAIVER AND PROVIDE INFORMATION REGARDING HOW TO PROCEED WITH THE LICENSING PROCESS. IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE OFFICE OF SPECIAL LICENSING AT (602) 364-2079.

CERTIFICATION OF SUPERVISION AND EXPERIENCE OF APPLICANT FOR WAIVER OF SPEECH-LANGUAGE PATHOLOGY LICENSING REQUIREMENTS

A.R.S. § 36-1940.04.B provides that the Director shall grant a waiver of the requirements for licensure as a speech-language pathology assistant until September 1, 2007 to individuals who have performed the functions of a speech-language pathology assistant and meet certain requirements. One of those requirements is that they have satisfactorily completed a minimum of two years of experience as speech-language pathology assistant under the supervision of a licensed master's level speech-language pathologist. The purpose of this certification form is to document that experience and supervision.

Name of Individual Requesting Waiver: _____

Name of Individual Certifying Supervision and Experience: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Please Answer The Following Questions: (Note - The duties/functions that may be performed by a speech-language pathology assistant in the State of Arizona are identified in A.R.S. § 36-1940.04.C.)

1. For how many months, and during what period(s) of time, did the individual requesting a waiver satisfactorily perform the functions of a speech-language pathology assistant under your supervision?

Number of Months	From (Month / Year)	To: (Month / Year)

2. During the period(s) that you provided supervision to the individual requesting a waiver, were you licensed as a master's level speech-language pathologist?

   Yes * No *

3. In what state were you licensed as a master's level speech–language pathologist when you provided supervision to the individual requesting a waiver? _____

4. What was your speech-language pathology license number when you provided supervision to the individual requesting a waiver? _____

I CERTIFY THAT THE INFORMATION PROVIDED ON THIS DOCUMENT IS TRUTHFUL, COMPLETE AND ACCURATE.

_____ _____

Signature of Certifying Individual Date

Attach this and any other required documentation to the Request for Waiver of Speech-Language Pathology Assistant Form